

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01361

CERTIFICATE OF DEATH

Reg. Dist. No. *mpo*

1. PLACE OF DEATH:

County..... *Talbot*
 City or town..... *Trappe (Rural)*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... *all of life*
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *MD* County..... *Talbot*
 City or town..... *Trappe (Rural)*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... *no*

3. (a) FULL NAME

Fannie Butler Baker

3. (b) Social Security Number

None

4. Sex..... *Female* 5. Color or race..... *white* 6.(a) Single, married, widowed, or divorced..... *widow*
 6.(b) Name of husband or wife..... *John W. Baker*
 7. Birth date of deceased (mo., day, yr.)..... *Oct. 22, 1862* 6.(c) If alive, give age..... years
 8. AGE: Years..... *84* Months..... *5* Days..... *10* If less than one day..... hrs. min.

9. Birthplace..... *Trappe Talbot Co., Md.*
(Town, county, and state)10. Usual occupation..... *Housewife*

11. Industry or business

12. Name..... *John Schuyler*13. Birthplace..... *Trappe, Talbot Co., Md.*14. Maiden name..... *John and Shetley*15. Birthplace..... *Trappe, Talbot Co., Md.*16. Informant..... *Charles Baker*Address..... *Trappe Md.*17. *Burial* Date thereof..... *Apr. 3, 1947*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... *Spring Hill*Location..... *Easton Md.*18. Funeral director..... *Maurice E. Newman, Son*Address..... *Easton Maryland*19. *April 24* 19 *47* *Joseph Baker* Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *April 1* 19 *47* at..... M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 28 19 *47* to..... *Apr 1* 19 *47*
and the last saw h. ex. alive on..... *Mar 31* 19 *47*Immediate cause of death..... *Acute myocarditis* DURATION..... *2 hrs*Due to..... *Pneumo-pneumonia* *4 days*Due to..... *Influenza* *2 weeks*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE..... *Joseph Baker* M. D. or otherAddress..... *Trappe Md.* Date signed..... *4/2/47*

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APR 5 1947
BUREAU V.A.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 172

CERTIFICATE OF DEATH

01362

Reg. Dist. No. 291

1. PLACE OF DEATH:

County Talbot County
 City or town St. Michaels, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot
 City or town St. Michaels, Md.
 (if outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edward D. Baynard, Jr.

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

B. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

April 24, 1937

8. AGE:

Years

Months

Days

If less than one day

1003

.....hrs.min.

B. Birthplace Memorial Hospital, Easton, Md.
 (Town, county, and state)
child

10. Usual occupation

11. Industry or business

FATHER

12. Name

Edward D. Baynard

13. Birthplace

Greensboro, Md.

MOTHER

14. Maiden name

Anna V. Kemp

15. Birthplace

St. Michaels, Md.

16. Informant

Edward M. Baynard

Address

St. Michaels, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

April 30, 1947
(month) (day) (year)

Cemetery or crematory

Olivet CemeterySt. Michaels, Md.

Location

Newnam & Harrison

18. Funeral director

St. Michaels, Md.

Address

19.

(Date rec'd by registrar)

19 47Wm. R. L. Smith

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 19 47 at C/30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death.....

DURATION

Accidental drowning
in boatDead

Due to.....

Due to.....

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4-27-47Where did injury occur? St. Michaels Talbot Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) riverMeans of injury drowning Injured at work? No

23. SIGNATURE

Louis J. Melby, M.D. Dep. Health

M. D. or other

Address Easton Md. Date signed 4-24-47

MARGIN RESERVED FOR BINDING

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01363

Reg. Dist. No. 291

1. PLACE OF DEATH:

County Talbot County
 City or town St. Michaels, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot
 City or town St. Michaels, Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James M. Baynard

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 8, 1940

8. AGE:

Years 6Months 8Days 19If less than one day
hrs. min.

9. Birthplace Memorial Hospital, Easton, Md.
 (Town, county, and state)

10. Usual occupation

Child

11. Industry or business

FATHER

12. Name Edward D. Baynard13. Birthplace Greensboro, Md.

MOTHER

14. Maiden name Anna V. Kemp15. Birthplace St. Michaels, Md.

16. Informant

Edward M. Baynard

Address

St. Michaels, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 30, 1947
(month) (day) (year)

Cemetery or crematory

Olivet Cemetery

Location

St. Michaels, Md.

18. Funeral director

Newnam & Harrison

Address

St. Michaels, Md.

19. (Date rec'd by registrar)

April 29, 1947

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 271947, at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to 19.....
 and that I last saw him alive on 19.....

Immediate cause of death

Accidental drowning

DURATION

Immediate

Due to

Fire on boat

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 4-27-47

Where did injury occur? N. St Michaels (City or town) Talbot (County) Md (State)

Injured at home, farm, industry, public place (where?) riverMeans of injury drowning Injured at work? no

23. SIGNATURE

Louis J. Neely, M.D.

M. D. or other

Address

Easton MdDate signed 4-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No. 01364
294

1. PLACE OF DEATH:

County ShenandoahCity or town Life
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Shenandoah County ShenandoahCity or town Shenandoah
(If outside city or town limits, write RURAL and give nearest town)Street No. Shenandoah
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Wanda Brooks

3. (b) Social Security Number

4. Sex Female 5. Color or race Col. 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age 1974 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: 23 Years Months Days If less than one day hrs. min.9. Birthplace Wittman Md.
(Town, county, and state)10. Usual occupation system checker11. Industry or business Packing house12. Name intentional

13. Birthplace

14. Maiden name Grace O. Brooks15. Birthplace Wittman Md.16. Informant Mary BrooksAddress Shenandoah Md.17. Burial Date thereof 4-22-47
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory ShenandoahLocation Shenandoah Md.18. Funeral director J. Thomas MuehlAddress Dr. Michael Md.19. Apr. 21 19 47 G. W. Sevel
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 19 47 at 10:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9, 1947 to April 18, 1947and that I last saw him alive on April 19 19 47Immediate cause of death DesheatedDURATION 6 hrsDue to CauseDue to blm

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury (Injured at work?)

23. SIGNATURE James Beeler MDAddress Shenandoah Md.Date signed Apr 20 1947

1940

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131-2)

01365

CERTIFICATE OF DEATH

Reg. Dist. No. 870

1. PLACE OF DEATH:

County 1st BaltCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 29 hrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 29 hrs.

3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

B. (b) Name of husband or wife Dr. Edna Carmine7. Birth date of deceased (mo., day, yr.) Oct. 8, 1865

6. (c) If alive, give age years

8. AGE: 81 Years Months Days If less than one day
hrs. min.9. Birthplace Preston - Caroline Co., Md.
(Town, county, and state)10. Usual occupation Rear Admiral - Coast Guard

11. Industry or business

12. Name Dr. Charles Carmine13. Birthplace Md.14. Maiden name Mary Fairclinton15. Birthplace Md.16. Informant Mrs. Edna CarmineAddress Preston Md.17. Cremation Date thereof April 14, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Burial - ArlingtonLocation Arlington, Va.18. Funeral director J. H. H. H. H.Address Preston, Md.19. 4/8 19 47 n. S. H. H.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County East CarolineCity or town Preston
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2. (a) If veteran, ✓ same war ✓

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1947 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 6 19 47 to Apr 7 19 47end that I last saw him alive on Apr 7 19 47Immediate cause of death Pulmonary edema - uremia

DURATION

3 daysDue to sclerotic kidneys ?Due to arterio sclerosis ?Due to Hypertrophy of Prostate ?Other conditions Dilatation of colon ?

(Include pregnancy within 3 months of death)

Major findings of operations noneDate of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Dr. SchneiderM. D. on 4/8/47Address Easton, Md. Date signed 4/8/47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 134

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Gaston (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Elizabeth

7. Birth date of

deceased (mo., day, yr.)

Sept. 18, 1865

8. AGE:

Years

Months

Days

If less than one day

8193

hrs.

min.

9. Birthplace

Caroline Co., Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

William C. Chance

13. Birthplace

Caroline Co., Md.

14. Maiden name

Louisa Brown

15. Birthplace

Caroline Co., Md.

16. Informant

Mrs. Nellie Fisher

Address

Gaston, Md.

17. (Burial, cremation, or removal, which?)

Cemetery or crematory

Frederick

Location

Frederick, Md.

18. Funeral director

Madeline Newman & Son

Address

Gaston, Md.

19. (Date rec'd by registrar)

4/2147N. St. Nevers

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Talbot

City or town

Gaston (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr. 21, 1947 at 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12:45 1947 to 1947 1947and that I last saw him alive on 1947 1947 1947

Immediate cause of death

Taken away to hospital

Due to

Due to

Other conditions

Chronic Alcoholism

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Phyllis Harrison M.D.

Address

24 E. Rome St. Easton, Md.

Date signed

4/21/47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01367

1. PLACE OF DEATH:

County Talbot
 City or town St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

John R. Dawson

3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Lucy Dean
 6. (c) If alive, give age 70 years
 7. Birth date of deceased (mo., day, yr.) Sept. 3, 1856
 8. AGE: Years 90 Months 6 Days 29 It less than one day _____ hrs. _____ min.

9. Birthplace Centerville, Maryland
 (Town, county, and state)
 10. Usual occupation Salesman

11. Industry or business

FATHER 12. Name Ienas Dawson
 13. Birthplace Church Hill, Md.
 MOTHER 14. Maiden name Jane Dillon
 15. Birthplace Church Hill, Md.

16. Informant Mrs. John R. Dawson
 Address St. Michaels, Md.

17. Burial Date thereof April 5, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Olivet Cemetery
 Location St. Michaels, Md.

18. Funeral director Newnam & Harrison
 Address St. Michaels, Md.

19. 4/12 47 John R. Dawson
 (Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1947 19____ at 6.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1947, to Apr. 2 1947,
 and that I last saw him alive on Apr. 1, 1947 19____

Immediate cause of death Uremia
 DURATION 3 days

Due to terminal stage
chronic nephritis - no renal
failure
 Due to kidney

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

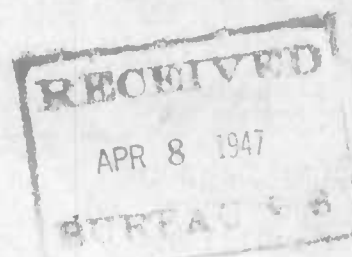
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE S. Dennis Waller, M.D.
 M. D. or other _____Address St. Michaels, Md. Date signed 4/2/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

01368

Reg. Dist. No. 292

1. PLACE OF DEATH:

County TackettCity or town Effort
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County TackettCity or town Effort
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Marion Ogden Driggs

3. (b) Social Security Number

4. Sex F. 5. Color of face W. 6. (a) Single, married, widowed, or divorced Unmarried.6. (b) Name of husband or wife Lawrence L. Driggs7. Birth date of deceased (mo., day, yr.) Oct. 14, 1875 6. (c) If alive, give age _____ years8. AGE: Years 71 Months 6 Days 5 If less than one day _____ hrs. _____ min.9. Birthplace Md.
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Marion Ogden13. Birthplace Effort, Md.14. Maiden name Kate Treaster15. Birthplace Md.16. Informant Ogden DriggsAddress Effort, Md.17. Cremation Date thereof April 21, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Eden Hill CemeteryLocation Washington, D.C.18. Funeral director Robert SackAddress Effort, Md.19. April 19 19 47 Joseph H. Rogers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 19 47, at 6:45 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 47 to 19 Apr 19 47and that I last saw her alive on 18 Apr 47 19 47Immediate cause of death Cerebral thrombosis

DURATION

3 wksDue to Cerebral arteriosclerosis

Due to _____

Other conditions No further renal condition or otherdisease

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Thomas Lee Harrison M.D.

M. D. or other

Address 204 E. Lane St. Effort Date signed 19 Apr 47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

Reg. Dist. No. 01362 292

1. PLACE OF DEATH

County TalbotCity or town Oxford
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Oxford Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Ida Green

3. (b) Social Security Number

4. Sex F 5. Color or race col. 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Edward Green7. Birth date of deceased (mo., day, yr.) Oct. 8, 1883 8. (c) If alive, give age _____ years8. AGE: Years 63 Months 6 Days 1 If less than one day _____ hrs. _____ min.9. Birthplace Trappe Talbot Md.
(Town, county, and state)10. Usual occupation House Wife

11. Industry or business

12. Name Nathan Stewart13. Birthplace Talbot Co.14. Maiden name Flora Campbell15. Birthplace Talbot Co.16. Informant Chas. Edward GreenAddress Oxford Md.17. Buried Date thereof 4/12/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Trappe CemeteryLocation Talbot Co.18. Funeral director Leon W. HenryAddress 310 South 5th Eastern Md.19. Apr. 10 - 47 Joseph J. [illegible]
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1947 at 2A: M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 6 1946 to April 9 1947and that I last saw him alive on April 9 1947Immediate cause of death Carcinoma of theColonDURATION 12 mo.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Hayward T. Nelt M.D.Address Eastern, Md. Date signed 4/9/47

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APR 21 1947

BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County... Talbot
 City or town... Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 1/2 years
 Hospital, institution, or street address where death occurred:
206 August Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md. County... Talbot
 City or town... Easton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 206 August St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Grace M. Harrison

3. (b) Social Security Number

None.

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

J. Oliver Harrison

7. Birth date of

deceased (mo., day, yr.) Apr. 21, 1890

6. (c) If alive, give age

60 years

8. AGE:

Years	Months	Days	If less than one day
<u>56</u>	<u>11</u>	<u>24</u>	<u>hrs. min.</u>

9. Birthplace

Royal Oak (Rural), Md.

10. Usual occupation

Housewife

11. Industry or business

Lewin G. Kilman

12. Name

Royal Oak, Md.

13. Birthplace

Sarah K. Harrison

14. Maiden name

Heavitt Md.

15. Birthplace

Mr. J. Oliver Harrison

16. Informant

Easton, Md.

17. (Burial, cremation, or removal. Which?)

Burial

18. Funeral director

Spring Hill

19. (Date rec'd by registrar)

Easton, Md.

20. DATE OF DEATH

Apr. 16, 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 April 1947 at 8:00 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

14 Apr 1947 to 13 Apr 1947and that I last saw him alive on 14 Apr 1947

Immediate cause of death

Carcinoma of the rectum

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

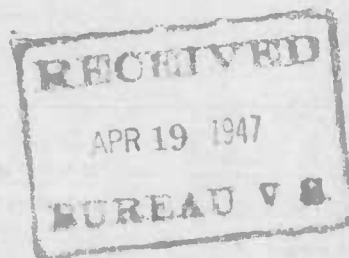
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thos. M. HarrisonAddress 206 E. Down St. Easton, MarylandDate signed 17 Apr 47



01371

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1370

CERTIFICATE OF DEATH

Reg. Diat. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 28 1/2 hours

Hospital, institution, or street address where death occurred:

Mar. Hospital - Easton, MarylandHow long in hospital or institution? 28 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Rural - Harlock
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mr. Fred Jacobs

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married6. (b) Name of husband or wife Mrs. Annie Jacobs7. Birth date of deceased (mo., day, yr.) OCT. 28, 1883
6. (c) If alive, give age 47 years8. AGE: Years Months Days If less than one day
63 5 14 _____ hrs. _____ min.9. Birthplace Harmony, Caroline, Md.
(Town, county, and state)10. Usual occupation Farming

11. Industry or business

12. Name Fred Jacobs13. Birthplace Maryland14. Maiden name Julia Camper15. Birthplace Maryland18. Informant Mrs. Annie L. JacobsAddress Williamsburg Md R117. Burial Date thereof 4/15/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ConcordLocation near Federalburg, Md18. Funeral director J. J. Thompson SonsAddress Federalburg Md.19. 4/14 19 47 N. R. Newnes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 19 47 at 10 18 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 11 19 47 to April 12 19 47and that I last saw him alive on April 12 19 47Immediate cause of death Pulmonary EdemaEcchymosisDue toChronic HypertensionDue toChronic HypertensionDue toChronic HypertensionDue toChronic HypertensionDue toChronic HypertensionDue toChronic HypertensionDue toChronic HypertensionDue toChronic HypertensionDue toChronic HypertensionDue toChronic HypertensionDue toChronic HypertensionDue toChronic Hypertension

DURATION

24 hours5 days10 days

Major findings of operations _____ Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. J. Thompson

M. D. or other

Address Thompson Date signed 4/15/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 19 1947

BUREAU 78

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01372

Reg. Dist. No. 291

1. PLACE OF DEATH:

County Talbot
City or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot
City or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Lorena Mae Johnson

3. (b) Social Security Number

none

4. Sex Female 5. Color or race color 6.(a) Single, married, widowed, or divorced child

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1945

8. AGE: Years 1 Months 3 Days 11 It less than one day hrs. min.

9. Birthplace St. Michaels
(Town, county, and state)

10. Usual occupation child

11. Industry or business

FATHER 12. Name Harold Johnson
13. Birthplace Bellevue, Md.

MOTHER 14. Maiden name Pearl Jackson
15. Birthplace St. Michaels, Md.

16. Informant Harold Johnson
Address St. Michaels, Md.

17. Burial Date thereof April 10, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery
St. Michaels, Md.
Location

18. Funeral director Newnam & Harrison
Address St. Michaels, Md.

19. april 9th 47 Mrs. Robert R. Seft
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1947 19 at 7 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dead on arrival 19 to 19
and that I last saw him alive on 19

Immediate cause of death Lobar Pneumonia DURATION 6 days

Due to

Due to

Other conditions ☒

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ☒ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury F. B. Shivers Injured at work?

23. SIGNATURE F. B. Shivers M. D. or other

Address St. Michaels, Md. Date signed 4.9.47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 15 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

01373

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
 City or town Easton, Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all of life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Talbot
 City or town Easton, Rural Unionville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Sophia Johnson

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Colored Widow

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 14, 1876

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

70712

hrs.

min.

9. Birthplace

Unionville, Easton, Md.
(Town, county, and state)

10. Usual occupation

Retired Cook

11. Industry or business

FATHER

12. Name

Zacharia Glasgow

13. Birthplace

Queen Anne Co., Md.

MOTHER

14. Maiden name

Maria Skinner

15. Birthplace

Easton, Rural, Md.

16. Informant

Address

John Cooper
Easton, Md.

17.

Burial
(Burial, cremation, or removal, Which?)Date thereof Apr. 28, 47
(month) (day) (year)

Cemetery or crematory

St. Stephens Churchyard

Location

Unionville, Easton, Rural, Md.

18. Funeral director

Address

John D. Williams
Easton, Md.

19.

4/25
(Date rec'd by registrar)19. 47W. H. Newman
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19. 47, at 1300 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 22 19. 47, to April 26 19. 47and that I last saw him alive on April 26 19. 47

Immediate cause of death

Pneumonia pneumonia

DURATION

4-5 days

Due to

Extreme exposure to weather

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harvard T. Webb, M.D.
M. D. or other _____
Address Easton, Md. Date signed 4/24/47

RECEIVED

MAY 3 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1962)

CERTIFICATE OF DEATH

01374

Reg. Dist. No. 291

1. PLACE OF DEATH:

County Talbot
 City or town Neavitt
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town Neavitt
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Edwin L. Jones

3. (b) Social Security Number

217-05-3714

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 8.(b) Name of husband or wife Nannie B. Camper
 6.(c) If alive, give age 49 years
 7. Birth date of deceased (mo., day, yr.) Oct. 8, 1892
 8. AGE: Years 54 Months 6 Days 4 If less than one day hrs. min.
 9. Birthplace Neavitt, Talbot Co., Md.
 (Town, county, and state)
 10. Usual occupation Toll Collector
 11. Industry or business

FATHER
 12. Name Daniel E. Jones
 13. Birthplace Neavitt, Md.
 MOTHER
 14. Maiden name Frances Bridges
 15. Birthplace Bozman, Md.
 16. Informant Mrs. Edwin L. Jones
 Address Neavitt, Md.

17. Burial Date thereof April 14/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cemetery
Neavitt, Md.
 Location
 18. Funeral director Newnam & Harrison
 Address St. Michaels, Md.

19. April 13 1947 Mr. R. L. Beck
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947 at 4:47 AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1947 to April 18 1947
 and that I last saw him alive on April 12, 1947
 Immediate cause of death Chronic Nephritis
 Due to Hypertension
 Due to
 Other conditions Hypertension
 (Include pregnancy within 8 months of death)

DURATION

2 yrs

Major findings of operations None Date of op. None
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide ✓ Date of ✓
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury P. D. Injured at work?
 23. SIGNATURE P. D. M. D. of father St. Michaels, Md.
 Address St. Michaels, Md. Date signed 4/13/47

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APR 15 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 daysHospital, institution, or street address where death occurred
Memorial HospitalHow long in hospital or institution? 30 days

3. (a) FULL NAME

Baby Boy Kelly4. Sex M 5. Color or race B 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 6, 19478. AGE: Years Months Days 30 If less than one day
30 hrs. 5 min.9. Birthplace Easton (Talbot Co.), Md.
(Town, county, and state)10. Usual occupation Newborn

11. Industry or business

12. Name Charles Wright13. Birthplace Easton Md14. Maiden name Aletia Kelly15. Birthplace S.C.16. Informant Hospital RecordsAddress Easton Md17. Burial Date thereof 4/5/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory RichardsLocation Easton Md18. Funeral director Low W. HenryAddress 310 South St Easton19. 4/4 47 N. J. Hopkins
(Date rec'd by registrar) (year) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County TalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 19 47 at 4 35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 6 19 47 to Apr 3 19 47and that I last saw him alive on April 2 19 47Immediate cause of death Pneumonia

DURATION

2 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Bull M. D. or otherAddress Easton Md Date signed 4-4-47

RECEIVED

APR 9 1947

SURF 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

01376

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Calvert
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 day
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 3 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent County
 City or town Rock Hall
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Thomas J. Kennard

3. (b) Social Security Number

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Widowed.

8. (b) Name of husband or wife

Go

7. Birth date of deceased (mo., day, yr.)

Jan. 7-1874

8. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

73

hrs. _____ min. _____

9. Birthplace

Rock Hall, Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER
MOTHER

12. Name

Wesley Kennard

13. Birthplace

Kent Co.

14. Maiden name

Janet Jones

15. Birthplace

Kent Co.

16. Informant

Catherine & Wesley
Rock Hall, Md.

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

April 5-1947
(month) (day) (year)

Cemetery or crematory

Chesertown, Md. R.D.

Location

18. Funeral director

asburg Henry

Address

Chesertown, Md.

19.

4/4
(Date rec'd by registrar)19 47N. A. Neer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3- 19 47 at 8:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 31 19 47 to April 3 19 47
and that I last saw him alive on April 3 19 47
u.m.

Immediate cause of death

Cardiac failure &
branchio-pneumonia - bilateral

Due to

systemic
hypertension
& chronic insufficiency

Due to

bilateral
myocardial
ischemia
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Wesley Kennard M.D.

M. D. or other

Address 214 E. Love St. Easton Date signed 8/4/47

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APR 11 1947

H. K. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and in full.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

01377

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 hr.Hospital, institution, or street address where death occurred:
Memorial HospitalHow long in hospital or institution? 1 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot CarolineCity or town Federalburg
(If outside city or town limits, write RURAL and give nearest town)Street No. S. Main Street
(If rural, give LOCATION)2(a) If veteran, name war ✓

3. (a) FULL NAME

Baby Girl Liden

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 3, 1947 6. (c) If alive, give age 1 hr. years8. AGE: Years Months Days If less than one day 1 hr. min.9. Birthplace Easton (Talbot Co.), Md.
(Town, county, and state)10. Usual occupation New born

11. Industry or business

12. Name Garrett B. Liden13. Birthplace Caroline Co.14. Maiden name Rene Arms15. Birthplace Kentucky16. Informant Memorial HospitalAddress Easton Md.17. (Burial, cremation, or removal. Which?) Cremation Date thereof 4/4/47
(month) (day) (year)Cemetery or crematory Memorial HospitalLocation Easton Md.18. Funeral director Memorial HospitalAddress Easton Md.19. 4/4 19 47 Dr. Neume
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 19 47, at 2:05 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 19 47 to April 3 19 47and that I last saw h.s. alive on April 3 19 47Immediate cause of death Prematurity 6 1/2 mo.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank M. Anderson M.D. M. D. or otherAddress Federalburg Md. Date signed 4/3/47

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APR 11 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot

City or town Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 7 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot

City or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Robert E. Miller

3. (b) Social Security Number

4. Sex M 5. Color or race B 6.(a) Single, married, widowed, or divorced M

8.(b) Name of husband or wife Virgie B. Miller

7. Birth date of deceased (mo., day, yr.) 1894 6.(c) If alive, give age _____ years

8. AGE: Years 63 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Bayman, Talbot, Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Edwin Miller

13. Birthplace St. Michaels, Md.

14. Maiden name Barrett Goldsborough

15. Birthplace Bayman, Md.

16. Informant Virgie B. Miller

Address St. Michaels, Md.

17. Buried Date thereof 4/28/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Michaels

Location St. Michaels, Md.

18. Funeral director Norman Frank

Address St. Michaels, Md.

19. 4/28 47 N. H. Newell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 19 47, at 12 35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death her cholecystitis

Due to _____

Due to _____

Other conditions Diabetes mellitus

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Norman Frank M. D.

Address 214 E. Ross St. Easton Date signed 6 May 47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 9 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

01379

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Talbot
City or town Neavitt
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Talbot
City or town Neavitt
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war.

3. (a) FULL NAME

Edward F. Newnam

3. (b) Social Security Number

none

4. Sex male 5. Color or race whitw 6. (a) Single, married, widowed, or divorced widower
6. (b) Name of husband or wife Hazel Irene Jones
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 14, 1887
8. AGE: Years 59 Months 9 Days 4 If less than one day hrs. min.

9. Birthplace Neavitt, Talbot Co., Md.
(Town, county, and state)
10. Usual occupation Waterman
11. Industry or business

FATHER 12. Name John S. Newnam
13. Birthplace Talbot Co., Md.
MOTHER 14. Maiden name Emma Shores
15. Birthplace Talbot Co., Md.
16. Informant Mrs. John T. Wayman Jr.
Address Neavitt, Md.

17. Burial Date thereof April 22, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cemetery
Neavitt, Md.
Location
18. Funeral director Newnam & Harrison
Address St. Michaels, Md.

19. Apr 20 19 47 Mrs. Robert L. Lott
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 April 19 47 at 5⁴⁰ P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 April 19 47 and that I last saw h. alive on unknown 19 47
Immediate cause of death Coronary thrombosis (presumptive)
Due to Heart disease (presumptive)
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

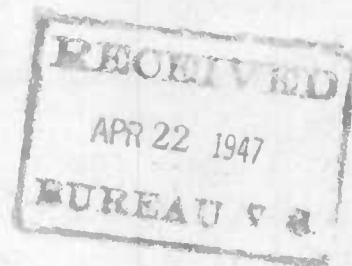
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dr. Herbert Morrison M. D. Seath
Address St. Michaels, Md. Date signed 19 Apr '47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

01380

Reg. Dist. No. 290

1. PLACE OF DEATH:

County... BaltimoreCity or town... Boston
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

111 Hanson Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... FallotCity or town... Boston
(If outside city or town limits, write RURAL and give nearest town)Street No. 111 Hanson
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Missouri Yashti Parson

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Col'd Widow

6. (b) Name of husband or wife... Alfred Parson7. Birth date of deceased (mo., day, yr.) March -19 - 1870
6. (c) If alive, give age... years8. AGE: Years Months Days If less than one day
77 12 hrs. min.9. Birthplace... Hartford Co. Maryland
(Town, county, and state)10. Usual occupation... Housewife

11. Industry or business

12. Name... William A. Bond13. Birthplace... Maryland14. Maiden name... Laura Virginia Perry15. Birthplace... Maryland18. Informant... Gertrude HoneyAddress... 111 Hanson St.17. Burial Date thereof... 4-7-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location... Boston, Maryland18. Funeral director... Leon H. HenryAddress... 114 S. Hanson Boston19. 45 47 N.H. Neuman
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 2 19 47 at 10:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 47 to April 2 19 47
and that I last saw him alive on Apr 2 19 47

Immediate cause of death

Bronchopneumonia

DURATION

Week

Due to

Due to

Other conditions

Pneumonia
Arthritis
(Include pregnancy within 3 months of death)Years

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE... W.F. Bull M.D. or otherAddress... Boston Date signed 4-3-47

RECEIVED

APR 9 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 146

01381

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County TalbotCity or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles P. Pinkney

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mildred Pinkney

7. Birth date of deceased (mo., day, yr.)

March 1, 19256. (c) If alive, give age 25 years

8. AGE:

Years

Months

Days

If less than one day

22119

hrs.

min.

9. Birthplace

Annapolis Anne Arundel Co. Md.
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

John Cooper

13. Birthplace

Talbot County

MOTHER

14. Maiden name

Christina Pinkney

15. Birthplace

Talbot County

16. Informant

Mildred Pinkney

Address

Clabonne, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

April 23, 1947
(month) (day) (year)

Cemetery or crematory

Clabonne Cemetery

Location

Clabonne Maryland

18. Funeral director

J. Norman Marshall

Address

St. Michaels, Maryland

19.

(Date rec'd by registrar)

April 24, 1947Mrs. Robert L. Seck
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Rural - St. Michaels
(If outside city or town limits, write RURAL and give nearest town)Street No. Clabonne, Maryland
(If rural, give LOCATION)2. (a) If veteran, name war World War II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 Apr 19 47, at P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death Bullet wound
shot - perforation of heart

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 19 Apr 47Where did injury occur? St. Michaels Talbot Maryland
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) public placeMeans of injury shot

Injured at work?

23. SIGNATURE.....

Thos. H. Hamilton M.D.Address 254 E. River St. Eastern Maryland M.D. or other MD
Date signed 20 Apr 47

RECEIVED

APR 28 1947

BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01382

Reg. Dist. No. 291

1. PLACE OF DEATH:

County Talbot
 City or town St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 mos.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Milton Robertson

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Mwhite

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 5/7/1946 6.(c) If alive, give age years8. AGE: Years Months Days If less than one day
10 24 hrs. min.9. Birthplace Wills River Talbot Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Milton Robertson
13. Birthplace Talbot Co.MOTHER 14. Maiden name Elychert M. Green
15. Birthplace Talbot Co.16. Informant (Mrs) Elychert Robertson
Address St. Michaels Md.17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 4/3/1947
(month) (day) (year)Cemetery or crematory Unionville Md.
Location Talbot Co.18. Funeral director Leon W. Henry
Address 310 South St. Easton Md.19. (Date rec'd by registrar) 4/24/47 19 47 Registrar John P. P. P. P.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 19 47 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Head on arrival 19 47 and that I last saw him alive on 19 47Immediate cause of death Infantile DiarrheaDue to UnrestrainedDue to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —Autopsy results — PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE J. P. HenryAddress St. Michaels Md. Date signed 4/24/47

DURATION

Unrestrained

RECEIVED
APR 8 1947
SECRET 13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01383

Reg. Dist. No. 270

1. PLACE OF DEATH:

County TalbotCity or town Eaton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 1/2 hours

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 13 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Bozman
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Elsie Sherwood

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 27, 1860

8. AGE: Years Months Days If less than one day

86 87 9 22 _____ hrs. _____ min.9. Birthplace Bozman - Talbot - Md.

(Town, county, and state)

10. Usual occupation H.W.

11. Industry or business _____

12. Name Benjamin McQuay13. Birthplace Bozman, Md.14. Maiden name Sarah L Jones15. Birthplace Bozman, Md.16. Informant Mr. John KeeperAddress Bozman Md.17. Burial Date thereof April 27, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CemeteryLocation Bozman Md18. Funeral director Reynolds & HarrisonAddress St. Michaels Md.19. 4/21 19 47 N.H. Neerius

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1947 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18 April 1947 to 19 April 1947and that I last saw h.c. cr alive on 19Immediate cause of death Stroke

DURATION

Due to Pract Simple NeckDue to Right Femur

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please endorse the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of 18 AprilWhere did injury occur? Bozman, Md. Talbot

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) HomeMeans of injury Fall Injured at work? _____23. SIGNATURE W. F. Kormanis MD.

M. D. or other _____

Address Eaton MD Date signed 22 April

RECEIVED
APR 30 1947
BUREAU 78

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-2

CERTIFICATE OF DEATH

01384

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
City or town Easton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all of life
Hospital, institution, or street address where death occurred
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Talbot
City or town Easton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, same war

3. (a) FULL NAME

Sarah Wilhelmina Smith

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1 - 1874

8. AGE: Years 72 Months 5 Days 7 hrs. min.

9. Birthplace Landing Neck, Easton, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Robt. A. Blann

13. Birthplace Caroline Co. Md.

14. Maiden name Anne Robinson

15. Birthplace Talbot Co. Md.

16. Informant Alfred Smith

Address Easton, Md.

17. Burial Date thereof Apr. 10 47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Hill Cemetery

Location Easton, Md.

18. Funeral director John D. Williams

Address Easton, Md.

19. 4/8 47 N. H. Merius
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 19 47 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 18 45 to April 8 47

and that I last saw him alive on April 5 47

Immediate cause of death Valvular heart disease

DURATION 3 yrs.

Due to

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William S. Seymour M. D. or other

Address Easton, Md. Date signed 4/10/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 16 1947

BUREAU 3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

Reg. Dist. No.

01385

794

1. PLACE OF DEATH:

County... Talbot
 City or town... Tilghman
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 months
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Talbot
 City or town... St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Sarah F. Waldron

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white widow

6. (b) Name of husband or wife Charles B. Waldron

7. Birth date of deceased (mo., day, yr.) July 21, 1865

8. AGE: Years Months Days If less than one day
81 8 22 hrs. min.9. Birthplace St. Michaels, Talbot Co., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Joseph Jefferson

13. Birthplace St. Michaels, Md.

14. Maiden name Susan Tarbutton

15. Birthplace St. Michaels, Md.

16. Informant Mrs. Newton George

Address Avalon, Maryland

17. Burial Date thereof April 14, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Olivet Cemetery

Location St. Michaels, Md.

18. Funeral director Newnam & Harrison

Address St. Michaels, Md.

19. 4-13 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947 of 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1947 to April 12 1947 and that I last saw him alive on April 11 1947

Immediate cause of death Cerebral Hemorrhage 2 days

Due to 1 1/2 hr. premonition 5 yr.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eugene P. Poles, M.D. M. D. or other

Address F. G. Lung Date signed 4-13-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 15 1947

BUREAU OF

100-4-1

100-4-1

100-4-1

100-4-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137-2

CERTIFICATE OF DEATH

01386

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Caroline
 City or town Denton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Ralph Walling

3.(b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced M

8.(b) Name of husband or wife Mrs. June Walling

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1868 6.(c) If alive, give age _____ years

8. AGE: Years 79 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace New York
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name George Walling

13. Birthplace New York

14. Maiden name Mary Ball

15. Birthplace New York

18. Informant J. J. Moore

Address Denton Md

17. Buried Date thereof 4-7-47
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Catholic Cemetery

Location Catholic Cemetery

18. Funeral director Regis. Mason & Co.

Address Denton, Md.

19. 4/6 19 47 N. H. Neuman
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 19 47 at 4 A M 92

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 19 47 to April 5 19 47 and that I last saw him alive on April 4 19 47

Immediate cause of death uremia
pyelonephritis

Due to Hypertrophic prostatic

Due to _____

Other conditions chronic myocarditis
arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations Large organized clot
in bladder & large prostate

Autopsy results _____ Date of op Apr 2, 1947

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

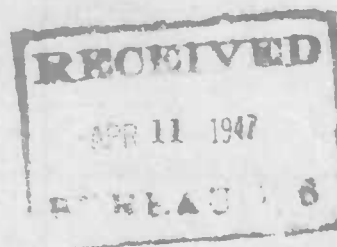
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. Schneider

Address Easton Md Date signed Apr 5, 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1276

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Calvert
 City or town Foston
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 hrs.
 Hospital, institution, or street address where death occurred:
Memorial Hospital Foston
 How long in hospital or institution? 7 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline
 City or town Federalburg Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed8.(b) Name of husband or wife Maida Marie W. Woughby7. Birth date of deceased (mo., day, yr.) April 16, 18608. AGE: Years 86 Months 11 Days 24 It less than one day _____ hrs. _____ min.9. Birthplace Federalburg, Caroline Co., Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business

12. Name Richard J. James W. Woughby13. Birthplace Federalburg, Caroline Co., Md.14. Maiden name Elizabeth Ann Andrews15. Birthplace Caroline Co., Md.16. Informant Maida Elizabeth PickensAddress Preston, Caroline Co., Md.17. (Burial, cremation, or removal. Which?) Burial Date thereof 4/6/47
(month) (day) (year)Cemetery or crematory Spring HillLocation Preston, Md.18. Funeral director Edis Clark Inc.Address Foston, Md.19. 4/5 47 N.D. Neirer
(Date rec'd by registrar) (Year) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 19 47 at 9:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 hrs. 19 47 to 4 hrs. 19 47and that I last saw him alive on 4 hrs. 19 47

Immediate cause of death _____

Due to Ruptured Gall Bladder

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

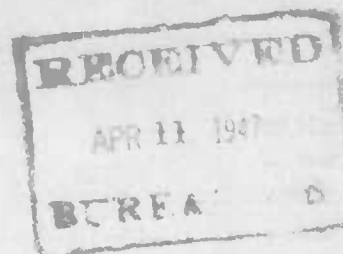
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul H. Harrison M.D.Address 214 E. Love St. Foston Date signed 8/4/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

Reg. Diat. No. 290

1. PLACE OF DEATH:

County Johns
 City or town Easton - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 years
 Hospital, institution, or street address where death occurred:
Copperville
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Talbot
 City or town Easton - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Copperville
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Clarence J. Wilson

3. (b) Social Security Number

None

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Jena P. Wilson
 7. Birth date of deceased (mo., day, yr.) December 27, 1886 6.(c) If alive, give age 42 years
 8. AGE: Years 60 Months 3 Days 20 If less than one day
 hrs. min.

9. Birthplace Queen Anne County, Maryland
(Town, county, and state)10. Usual occupation Clergyman11. Industry or business Methodist Church12. Name Henry Wilson13. Birthplace Queen Anne County, Maryland14. Maiden name Martha Burgess15. Birthplace Queen Anne County, Maryland16. Informant Mrs. Jena P. WilsonAddress Easton, Maryland, R.F.D. #117. Burial Date thereof April 22, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Copperville Colored CemeteryLocation Copperville, Maryland18. Funeral director J. P. Braxton and SonAddress Federalburg, Maryland19. 4/21 47 N. H. Neuman
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1947 at 11:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1947 to April 17 1947and that I last saw him alive on April 17 1947

Immediate cause of death

United States CorcinomaDue to ca of Reticulum

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations John HopkinsDate of op. Sept 44

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Buell M. D. or otherAddress Easton Md Date signed 4-20-47

RECEIVED

APR 24 1947

BUREAU 74

Evidence for change of
age shown on?

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Md

01388

FILM No. G 110 MAY 12 1947 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

62

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

16. Funeral director

Address

19.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 29

19

47

at

4 P

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October

19

46

to

April

19

47

and that I last saw her alive

April

19

47

Immediate cause of death

Left # pericardial

DURATION

Failure

Due to

Hypertension and
vascular heart

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William S. Suppawes

M. D. or other

Address

Easton Md

Date signed

May 1/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1947

BUREAU